STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 3/13/18 through 3/16/18. Also reviewed during the course of the survey was complaint intake WY00002475. The following common abbreviations are used through this document: CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 604		4/20/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/06/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 604	Continued From page 1 §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure 3 of 12 sample residents (#12, #15, #24) were free from unnecessary physical restraints. The findings were: 1. Observation on 3/12/18 at 3:03 PM showed resident #12 was in bed with a bed rail in use on the upper right side of the bed and a wedge device secured to the left side of the bed. The following concerns were identified: a. Review of the quarterly MDS assessment dated 12/26/17 showed the resident had diagnoses which included Alzheimer's dementia and rheumatoid arthritis. Further, the resident required total assistance of 2 staff members for bed mobility. b. Review of a physical restraint evaluation completed on 2/8/18 showed the device was used for boundary identification because the resident was immobile and required total assistance. There was no evidence the resident had been evaluated to determine the least restrictive device or identify safety risks. c. Interview with the DON on 3/15/18 at 10:06 AM revealed the wedge was implemented because the resident would "curl up into a ball"	F 604	F604 Resident #12 and #24's side rails, wedges and alarms were removed 03/16/2018. Resident #15 was seen by her Physician to reassess Left hip fracture from 2013. Determination made by MD to continue Lap Buddy to ensure limited weight bearing. MD plans to reassess Quarterly. 100% of CCMSD residents were audited by DON for restraint use using an audit tool. Restraints that were identified during the audit were removed immediately. Nursing staff will be educated, by DON or designee, on F604 to ensure understanding of F604. Competency will be established using an assessment tool. All requests for restraints will be discussed in IDT weekly meeting and PRN.	

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F 604	Continued From page 2 and almost fall out of bed. Continued interview revealed the resident was unable to remove the wedge without assistance. 2. Observation on 3/12/18 at 3:32 PM showed resident #24 was in bed with the right side of the bed pushed up against the wall and a wedge placed behind the resident on the left side of the bed. Further, the resident had an alarm attached to his/her shirt which was secured to the head of the bed. Observation on 3/14/18 at 9:23 AM showed the resident was in bed with the right side of the bed pushed up against the wall and a wedge placed behind the resident on the left side of the bed. At that time, the resident had an alarm attached to his/her shirt which was secured to the head of the bed. The following concerns were identified: a. Review of the 12/7/17 quarterly MDS assessment showed the resident had diagnoses which included Alzheimer's dementia, osteoporosis, seizure disorder, and depression. Further, the resident required extensive assistance of 2 staff members for bed mobility. b. Review of a physical restraint evaluation dated 3/14/18 showed the device was used for boundary identification because the resident was immobile and required staff to move him/her. There was no evidence the resident had been evaluated to determine the least restrictive device or identify safety risks. c. Interview with the MDS coordinator on 3/15/18 at 10:05 AM revealed the wedge was used for perimeter identification, the resident hugged the wedge like a body pillow, and it was not necessary when the resident was facing the wall. d. Interview with the DON on 3/15/18 at 10:05 AM revealed the facility did not assess	F 604	Assessments for safety risk, least restrictive device, orders and consents will be obtained and reviewed with the MD and family prior to implementation. The DON or designee will audit 4 residents weekly for 4 weeks using an audit tool to ensure compliance with F604. Any variances will be corrected and staff educated immediately. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. 04/20/2018	

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F 604	Continued From page 3 wedges as restraints and did not evaluate the safety of the devices. 3. Review of the 2/14/18 quarterly MDS assessment showed resident #15 had severe cognitive impairment and required extensive physical assistance with transfers and mobility. Further review showed the resident had Alzheimer's dementia; and a trunk restraint and floor pad alarm were used daily. Review of the care plan, revised on 3/5/18, showed staff used physical restraints (Lap Buddy) due to poor safety awareness and confusion. Observation on 3/14/18 at 8:50 AM showed the resident sat in a wheelchair with lap buddy in the dining room. At 9:08 AM, continued observation revealed two staff provided minimal assistance as the resident stood and moved from the wheelchair to his/her bed. The following concerns were identified. a. Review of the 2/21/17 consent form for lap buddy use showed "high fall risk", "end stage Alzheimer's," "unaware of safety needs," and " has a pinned hip fracture and is non- weight bearing except to transfer." b. Interview on 3/15/18 at 8:41 AM with the DON revealed the Lap Buddy was applied in 2013 after the resident fell; and the physician determined the resident could not be full weight-bearing due to an unstable hip pinning. She further stated the resident had only 2 non injury falls in the past 3 years. c. Review of the quarterly 2015 to 2018 restraint use assessments showed staff continued to reassess the resident's need for the restraint based the resident's non-weight bearing status after s/he fell in 2013. d. Interview on 3/15/18 at 9 AM with the DON revealed the resident's ability to bear weight had not been reassessed since 2013.	F 604		

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F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a significant change assessment was completed for 1 of 13 sample residents (#130) reviewed for change in condition. The findings were: Review of the 6/13/17 admission MDS assessment showed resident #130 had moderately impaired cognition, independent activities of daily living, no psychiatric medication, and no behaviors. The following concerns were identified: a. Review of the medication orders showed the physician ordered daily doses of Klonopine for the resident's behaviors on 7/26/17. b. Review of the 6/30/17 nursing note showed the resident was friendly and pleasant but resistant to baths, "Angers if friend is upset," incontinent of bowel and bladder, wandered from door to door looking for a way out to go home and needed frequent redirection. c. Review of the 7/1/17 nursing note showed	F 637	F637 Resident #130 was discharged on 08/15/2017. 100% audit of all residents was completed by DON to assess for significant change assessment need using an audit tool. No significant change findings were identified. The IDT team was re-educated on F637 using the RAI manual. All residents in their MDS look back period will be reviewed in the weekly IDT meeting for possible significant change assessment need. Any residents found with significant change will have Significant Change MDS initiated at that time.	4/20/18

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F 637	Continued From page 5 the resident was alert, confused, agitated, and redirected out of other resident rooms. The resident wore a Wanderguard and had poor safety awareness. The resident was looking for a way home. d. Review of the 7/5/17 nursing note showed the resident wandered throughout the facility, was an elopement risk, and became agitated when staff redirected him/her. e. Review of the 8/7/17 nursing note showed the resident was uncooperative, refused care, was threatening to visitors and staff, and difficult to reason with. During an interview on 3/15/18 at 10:52 AM, the MDS coordinator acknowledged the changes in the resident's behavior and addition of the psychiatric medication that were noted after she developed the admission MDS assessment and prior to the resident's discharge in August 2017. She further stated she did not develop a significant change MDS to address the changes because this was the only area of change for the resident.	F 637	The DON or designee will audit 2 residents weekly for 4 weeks using an audit tool to ensure compliance of F636. Any variances will be corrected and staff educated immediately. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		4/20/18

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F 656	Continued From page 6 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to develop a are plan for 7 of 12 sample residents (#12, #13, #16, #21, #24, #28, #132) who had bed rails and/or restraints. The findings were: 1. Observation on 3/12/18 at 3:03 PM showed resident #12 was in bed with a half bed rail in use	F 656	F656 All restraints were removed from Residents #12, 13, 16, 21, 24, 28 and 132. Care plans have been reviewed and updated to reflect that there are no side rails or other restraints in use.	

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F 656	Continued From page 7 on the upper right side of the bed and a wedge device secured to the left side of the bed. Review of the quarterly MDS assessment dated 12/26/17 showed the resident had diagnoses which included Alzheimer's dementia and rheumatoid arthritis. Further, the resident required total assistance of 2 staff members for bed mobility. Review of a physical restraint evaluation completed on 2/8/18 showed the device was used for boundary identification because the resident was immobile and required total assistance. Review of the care plan, last revised on 12/31/17, showed no evidence the bed rail or wedge was care-planned for appropriate use or safety concerns. 2. Observation on 3/12/18 at 3:32 PM showed resident #24 was in bed with the right side of the bed pushed up against the wall and a bolster pillow behind the resident on the left side of the bed. Further, the resident had an alarm attached to his/her shirt which was secured to the head of the bed. Observation on 3/14/18 at 9:23 AM showed the resident was in bed with the right side of the bed pushed up against the wall and a bolster pillow placed behind the resident on the left side of the bed. At that time, the resident had an alarm attached to his/her shirt which was secured to the head of the bed. Review of the 12/7/17 quarterly MDS assessment showed the resident had diagnoses which included Alzheimer's dementia, osteoporosis, seizure disorder, and depression. Further, the resident required extensive assistance of 2 staff members for bed mobility. Review of a physical restraint evaluation dated 3/14/18 showed the bolster pillow was used for boundary identification because the resident was immobile and required staff to move him/her. Review of the care plan,	F 656	100% of CCMSD residents' care plans were audited by DON for restraint use care planning using an audit tool. Any errors in the care plans will be updated immediately. IDT and anyone updating care plans will be educated, by DON or designee, on F656 to ensure understanding. Competency will be established using an assessment tool. All requests for restraints will be discussed in IDT weekly meeting and PRN. Care plans will be reviewed/updated at that time, with each Care plan review and PRN. The DON or designee will audit 4 residents' care plans weekly for 4 weeks using an audit tool to ensure compliance. Any variances will be corrected and staff educated immediately. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. 04/20/2018	

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F 656	Continued From page 8 last revised on 12/31/17, showed no evidence the bolster pillow was care-planned for appropriate use or safety concerns. 3. Observation on 3/12/18 at 3:48 PM showed resident #13's bed had half bed rails which were in use on the upper portion of the bed, on both sides. Observation on 3/14/18 at 4:34 PM showed the bed rails were designed to have 2 gaps which measured 5 1/2 inches in height by 7 inches in width and 2 gaps which measured 7 1/2 inches in height by 2 inches in width. Review of the care plan, last revised on 2/7/18, showed no evidence the side rails were care-planned for appropriate use or safety concerns. 4. Observation on 3/13/18 at 10:21 AM showed resident #132's bed had a half bed rail in use on the upper left side of the bed, which was against the wall. Observation on 3/14/18 at 4:34 PM showed the resident's bed had half bed rails which were in use on the upper portion of the bed, on both sides. The bed rails were designed to have 2 gaps which measured 4 inches in height by 7 inches in width and 1 gap which measured 4 1/2 inches in height and 2 inches in width. Review of the care plan, last revised on 3/7/18, showed no evidence the side rails were care-planned for appropriate use or safety concerns. 5. Observation on 3/12/18 at 3:15 PM showed resident #21 was resting in bed. Further observation revealed the bed had half bed rails which were in use on the upper portion of the bed, on both sides. Observation on 3/14/18 at 4:34 PM showed the bed rails were designed to have 2 gaps which measured 5 1/2 inches in height by 7 inches in width and 2 gaps which	F 656		

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F 656	Continued From page 9 measured 7 1/2 inches in height by 2 inches in width. Review of the care plan, last revised on 1/4/18, showed interventions for safety concerns and appropriate use for bed rails were lacking. 6. Observation on 3/12/18 at 3:22 PM showed resident #28 was resting in bed. Further observation revealed the right upper bed rail was up. Observation on 3/14/18 at 4:34 PM revealed the bed rail was designed with 7 gaps. Two of the gaps measured 3/1/2 inches x 6 1/2 inches. Two of the gaps measured 4 inches x 7 1/2 inches. Two of the gaps measured 2 1/4 inches x 7 1/2 times inches and one gap measured 2, 4 x 8, and 3 1/2 x 7. Review of the care plan, last revised on 1/10/18, showed interventions for safety concerns and appropriate use for bed rails were lacking. 7. Observation on 03/12/18 at 3:29 PM showed resident #16 was sitting in a recliner chair and the upper bed rail on the bed was up. Interview with the resident at that time revealed staff put the bed rail up sometimes when s/he was in bed; but s/he was not sure why staff did that. Review of the "Side Rail Evaluation" dated 1/18/18 showed bed rails were not used. Further review showed no evidence the bed rails were assessed for entrapment or a bed rail consent was obtained. Interview with the DON on 3/15/18 at 8:57 AM revealed the bed rails were used because the resident requested it, but this was not added to the care plan, it was not assessed for entrapment and a consent had not been obtained. 8. Interview with the MDS coordinator on 3/14/18 at 2:29 PM revealed the bed rail use and wedges or "bolster pillows" should be on the care plan; however, she was aware she had missed some of them. Further, the facility reviewed the care	F 656		

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F 656	Continued From page 10 plan at quarterly meetings and added them if they notice they were missed.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview the facility failed to develop an effective system for monitoring pressure ulcers for 1 of 1 sample resident (#131) with pressure ulcers. Review of the medical record showed resident #131 was admit on 2/20/18 and the nursing admission assessment showed the resident had a healed pressure ulcer on the sacrum. Review of the 3/5/18 admission MDS assessment showed s/he had diagnoses that included heart failure, dementia, and arthritis, and had moderate cognitive impairment. Further review revealed s/he was at risk for developing pressure ulcers, but did not have any pressure ulcers. The resident required limited assistance with most	F 686	F686 On 04/04/2018 the DON conducted a wound assessment and pressure injury risk assessment on resident #131. Assessments were documented immediately. Current treatment orders are reviewed and determined by DON and MD to be appropriate. Care plan is updated to reflect current treatment plan. Skin assessments are completed one time per week and PRN. Staff will be educated on F 686 and	4/20/18

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F 686	Continued From page 11 activities of daily living. The following concerns were identified: a. Observation of the resident on 3/14/18 at 10 AM revealed the resident had a stage II open area on the coccyx gluteal fold. b. Review of the 3/9/18 nursing notes showed the resident had a 0.5 cm x 0.2 cm pressure ulcer noted to her coccyx in the gluteal fold: "Wound presents as a stage 1. Wound bed is covered with a thin fragile layer of epithelial cells. Area is light pink and non-blanching at this time. no drainage and no odor noted at this time. Area was cleansed with warm soapy water, patted dry, skin prep applied to peri-wound, and a Mepilex dressing was placed." c. Review of the 3/13/18 nursing notes showed the resident had a 0.4 cm x 0.2 cm x 0.1 cm stage 2 pressure ulcer noted to her coccyx in gluteal fold: "Wound was opened up. Edges are regular. Wound bed was clean light pink. small amount of serosanguineous drainage was noted to Mepilex. No odor noted at this time. Peri-wound is a medium red color and blanching. Area was cleansed with warm soapy water, patted dry, skin prep applied to peri-wound, and a bordered duoderm dressing was placed. Resident stated the wound was tender." d. Review of the facility's skin care monitoring system for the resident revealed inconsistent documentation, making it difficult to determine when the pressure ulcer developed and whether it had improved. e. During interview on 3/15/18 09:10 AM, the DON revealed the admission nurse said the area was healed, then three days after admission the wound nurse said it was an opened stage 2 pressure ulcer. The DON stated the wound care nurse documented it was a stage 1 eight days later, then five days later said it was a stage 2.	F 686	competency will be assessed using an assessment tool. All pressure injuries will be reported to the charge nurse and the wound nurse. Pressure injuries will be assessed, reported to MD and a treatment plan will be initiated and documented. All pressure injuries will be discussed in IDT to ensure compliance. Any found to be not in compliance will be corrected and staff educated immediately. The DON or designee will audit 2 residents' skin assessment weekly for 4 weeks using an audit tool to ensure compliance. Any variances will be corrected and staff educated immediately. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. 04/20/2018	

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	535029	A. BUILDING _____ B. WING _____	03/16/2018

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F 686	Continued From page 12 The DON further stated assessment and documentation of pressure ulcers had been a problem and this made it difficult to determine whether the pressure ulcer was improving or deteriorating	F 686		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to ensure all were met for 6 sample residents (#12, #13, #16, #21, #28, #132) who had bed rails. The findings were:	F 700	F 700 Residents # 12, 13, 16, 21, 28, and #132 all have their side rails removed. 100% of CCMSD residents were audited by DON	4/20/18

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F 700	Continued From page 13 1. Observation on 3/12/18 at 3:03 PM showed resident #12 was in bed with a bed rail in use on the upper right side of the bed and a wedge device secured to the left side of the bed. Observation on 3/14/18 at 4:34 PM showed the bed rail was designed to have 4 gaps which each measured 3 inches in height by 6 inches in width. The following concerns were identified: a. Review of the "Side Rail Evaluation" dated 2/8/18 showed the resident was totally dependent on staff to get in and out of bed and for all ADLs. Further review showed no evidence that the bed rails were assessed for entrapment or that informed consent for a bed rail was obtained. 2. Observation on 3/12/18 at 3:48 PM showed resident #13's bed had half bed rails which were in use on the upper portion of the bed on both sides. Observation on 3/14/18 at 4:34 PM showed the bed rails were designed to have 2 gaps which measured 5 1/2 inches in height by 7 inches in width and 2 gaps which measured 7 1/2 inches in height by 2 inches in width. The following concerns were identified: a. Review of the "Side Rail Evaluation" dated 2/7/18 showed the resident required limited assistance of staff to get in and out of bed and the resident requested the use of bed rails. Further review showed no evidence that the bed rails were assessed for entrapment or that informed consent for a bed rail was obtained. 3. Observation on 3/13/18 at 10:21 AM showed resident #132's bed had a half bed rail in use on the upper left side of the bed which was against the wall. Observation on 3/14/18 at 4:34 PM showed the resident's bed had half bed rails in use on the upper portion of the bed, on both sides. The bed rails were designed to have 2	F 700	for side rail use using an audit tool. Side rails that were identified during the audit were removed immediately. Nursing staff will be educated, by DON or designee, on F700 to ensure understanding of the circumstances that require the use of side rails and the hazards associated with their use. Competency will be established using an assessment tool. All requests for side rails will be discussed in IDT weekly meeting and PRN. Assessments for safety risk, entrapments and appropriateness will be conducted, and consents will be obtained and reviewed with the MD and family prior to implementation. The DON or designee will audit 4 residents weekly for 4 weeks using an audit tool to ensure that side rails are not being used without the proper process as listed above. These residents will be assessed and interviewed/observed to ensure compliance. Any variances will be corrected and staff educated immediately. This plan of correction will be monitored at the	

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F 700	Continued From page 14 gaps which measured 4 inches in height by 7 inches in width and 1 gap which measured 4 1/2 inches in height and 2 inches in width. The following concerns were identified: a. Review of the "Side Rail Evaluation" dated 2/22/18 showed the resident required extensive assistance of staff to get in and out of bed and the resident requested the use of bed rails. Further review showed no evidence that the bed rails were assessed for entrapment or that informed consent for a bed rail was obtained. 4. Observation on 3/12/18 at 3:15 PM showed resident #21 was resting in bed. Further observation revealed the bed had half bed rails in use on the upper portion of the bed on both sides. Observation on 3/14/18 at 4:34 PM showed the bed rails were designed to have 2 gaps which measured 5 1/2 inches in height by 7 inches in width and 2 gaps which measured 7 1/2 inches in height by 2 inches in width. The following concerns were identified: a. Review of the "Side Rail Evaluation" dated 3/4/18 showed the resident required assistance of staff to get in and out of bed and the resident's family requested the use of bed rails. Further review showed no evidence that the bed rails were assessed for entrapment or that informed consent for a bed rail was obtained. 5. Observation on 3/12/18 at 3:22 PM showed resident #28 was resting in bed. Further observation revealed the right upper bed rail was up. Observation on 3/14/18 at 4:34 PM revealed the bed rail was designed with 7 gaps. Two of the gaps measured 3 1/2 inches x 6 1/2 inches. The following concerns were identified: a. Review of the "Side Rail Evaluation" dated 2/1/17 showed staff used a mechanical lift to	F 700	monthly Quality Assurance meeting until such time consistent substantial compliance has been met. 04/20/2018	

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F 700	Continued From page 15 transfer the resident in and out of bed and the resident used the rail for positioning. Further review showed no evidence that the bed rails were assessed for entrapment or that informed consent for a bed rail was obtained. 6. Observation on 3/12/18 3:29 PM showed resident #16 was sitting in a recliner chair and the upper bed side rail on the bed was up. Interview with the resident at that time revealed staff put the bed rail up sometimes when s/he was in bed; but s/he was not sure why staff did that. The following concerns were identified: a. Review of the "Side Rail Evaluation" dated 1/18/18 showed bed rails were not used. Further review showed no evidence that the bed rails were assessed for entrapment or that informed consent for a bed rail was obtained. b. Interview with the DON on 3/15/18 at 8:57 AM revealed the bed rails were used because the resident requested it, but this was not added to the care plan, it was not assessed for entrapment and a consent had not been obtained. 7. Interview with the DON on 3/14/18 at 4:53 PM revealed the facility did not assess bed rails for entrapment risk and did not obtain written consent for bed rail use.	F 700		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		4/20/18

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F 812	Continued From page 16 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure food was stored in a sanitary environment in 1 of 1 food preparation area (main kitchen). The findings were: 1. Observation of the walk-in cooler on 3/12/18 at 2:42 PM showed an opened bag of sliced onions that did not have a label or use by date. 2. Observation of the dry storage room on 3/12/18 at 2:45 PM showed a clear plastic bag labeled "vanilla pudding" which had a white powdery substance in it and had an expiration date of 3/2/18. Further observation showed a clear plastic bag labeled "pudding mix" which had an off-white colored powdery substance in it and had an expiration date of 1/8/18. Observation on 3/14/18 at 11:24 AM showed the "vanilla pudding" and "pudding mix" were still in the storage area. 3. Interview with the dietary manager on 3/14/18 at 11:24 AM revealed stored items should always have labels and an expiration date. Further, she confirmed that all items in the dry storage and the refrigerators were available for resident	F 812	F812 All outdated or improperly labeled food was removed by the CDM on 03/15/2018 100% of all food in the kitchen was audited, by CDM, using an audit tool to ensure that food is properly labeled and not outdated. All kitchen staff will be educated, by CDM, on F812 and the strategies to maintain compliance with F812. A daily checklist of all perishable foods was developed to remind staff to label and dispose of foods that are outdated. The CDM will audit perishable food items and the checklist weekly x 4 weeks to ensure compliance with F812. Any food found improperly labeled or	

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F 812	Continued From page 17 consumption. 4. According to Food Code 2013, U.S. Public Health Service: 3-501.17 "(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (D) and (E) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days."	F 812	outdated will be disposed of and staff educated immediately. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. 04/20/2018	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		4/20/18

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F 880	Continued From page 18 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 19 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure hand hygiene was performed for 1 of 7 sample residents (#19) who received incontinence care. The findings were: Observation on 3/13/18 at 11:02 AM showed CNA #1 entered the room of resident #19, donned gloves, and provided perineal care to the resident, who had been incontinent of bladder. After performing the care, the CNA removed the gloves and repositioned the resident. Without performing hand hygiene, the CNA took a bag of trash out of the room, walked down the hallway, and entered the soiled utility room. Upon leaving the soiled utility room, the CNA used hand sanitizer gel and then entered another resident room to perform care. Interview with the infection preventionist on 3/15/18 at 11:18 AM revealed handwashing should be performed when hands are visibly soiled or dirty, when the resident has a suspected organism, or when leaving the bathroom. Review of the facility's policy titled "Handwashing/Hand Hygiene" last revised 4/2012 showed "...5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water	F 880	F880 CNA #1 was educated on F880 and demonstrated competency on hand hygiene. CCMSD's Hand Hygiene policy was updated. The facility has determined that all residents have the potential to be affected. All Nursing staff will be educated, by the DON or designee, on F880 and the Hand Hygiene policy and will demonstrate competency using the Hand Hygiene validation checklist. The DON or designee will complete 4 random audits weekly x 4 weeks, using the Hand Hygiene validation checklist as an audit tool to ensure each staff member is compliant with F880 and the Hand Hygiene Policy. Any variances will be corrected and staff re-educated immediately. This plan of correction will be monitored at the monthly Quality Assurance meeting until such	

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F 880	Continued From page 20 under the following conditions:...c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice);...h. Before and after assisting a resident with personal care (e.g., oral care, bathing);...n. Before and after assisting a resident with toileting (hand washing with soap and water);...q. After contact with a resident's mucous membranes and body fluids or excretions;...u. After removing gloves or aprons;..."	F 880	time consistent substantial compliance has been met. 04/20/2018	